'Talk' about male suicide? Learning from community programmes.
4996 words

Introduction

This paper reflects on a recent regional suicide prevention public awareness campaign, part of the Scottish national Choose Life programme, in order to explore emerging considerations for suicide prevention programme development. The paper summarises key qualitative findings from the formative evaluation of the public awareness campaign, which placed particular emphasis on men. These findings, which particularly focus on processes of change, are discussed in the context of wider evidence and considerations about masculinity. It is especially important to focus on processes of change in evaluating public awareness programmes around suicide prevention, given the complexity of suicide prevention. For example, a key dimension is to foster culture change in public attitudes to male suicide, which is likely to require understanding as a complex and on-going, rather than rapid and straightforward process, involving as it does considerations of of stigma around mental ill-health, and of masculinity.

Suicide rates across Europe are over 3 times higher for men than women (European Commission, 2011). Suicide accounts for over two-thirds of fatal injuries among young people (15-24 years), and remains the leading cause of death in men in the 30-39 age range in the EU27 countries (European Commission, 2011). In the UK, while suicide rates have tended to be highest among young men aged 15–44, rates for men aged 45–74 have been increasing, and in 2010 this age group had the highest rates (Office of National Statistics, 2012). Reflecting similar trends, in Scotland, where around three-quarters of suicides are men, over the latest five years, the largest numbers of suicides have been in the age-groups 40-44; 35-39; 45-49; and 30-34 respectively (General Register Office for Scotland, 2012). By 2009 the highest suicide rate for males was in the 30-39 age range, followed by 40-49 (Samaritans, 2011).

Suicide prevention work is inseparable from addressing inequalities and social exclusion (Scottish Government, 2010) and Socio-economic inequalities in suicide are pervasive across Europe (Lorant et al., 2005). In Scotland, suicide rates in the most deprived 30% of areas are significantly higher than the national average (The Scottish Public Health Observatory, 2012). Prolonged unemployment is also a major risk factor (Stuckler et al., 2009; McLean et al., 2008; Kinderman et al., 2008; Institute of Public Health in Ireland, 2011), with correlations between male suicide rates and rising unemployment across European and Asian countries (Cooper, 2011; Pritchard, 1992; Chang et al., 2009).

The complexity of suicide has been understood in terms of risk and protective factors. A systematic review for the Scottish Government identified socio-economic risk factors, with substance misuse, histories of mental illness, previous self-harm, and other individual factors. Protective factors include employment, family connectedness, and social support (McLean et al; 2008). However, this remarkably *ungendered* model does not account for high male rates. The review found 'gaps in evidence' concerning possible risk including isolation and non-help seeking, and around possible protective values of help-seeking, neighbourhood quality and social capital. These 'missing' aspects will intersect with gender, influencing suicide and suicide prevention. There are indications, which we explore, that specific qualities of *social connectedness* around communicating vulnerability may help protect people from suicide. This focus on communication, and its gendered dimension, provides a core rationale for a campaign emphasising talk about suicide among men.

The ways men are socialised to communicate vulnerability and the ways others communicate can constitute a *risk factor* for men's mental health (Wilkins, 2010). Evidence suggests fewer men than women would talk to friends about their feelings if they were unhappy (Mind, 2009), with lower male levels of social support and contact with friends (Pevalin and Rose, 2003). Given lower social support and trust, people are more likely to report feelings of poor health and wellbeing (Boreham

et al., 2000). A further issue concerns stigma around mental health (Goffman, 1963). Social concerns around men communicating vulnerability can interact with the fact that, assigned a label of mental illness, a person may take on a stigmatised identity (Corrigan and Wassel, 2008), further strengthening the perceived risk for men of talking about mental health or suicide. When men are also positioned as marginalised (e.g. by long-term unemployment, homelessness, or sexuality), this presents complex disincentives to communicating a need for help. Particular groups of men may mistrust some services, associating them with negative experiences (European Commission 2010), which acts as a further deterrent. Non-recognition or non-communication of emotional vulnerability contributes to under-diagnosis of male mental health concerns (Kilmartin, 2005). Understanding the interaction of gender and other, complex, risk and protective factors (Samaritans, 2012) is therefore paramount for the direction of suicide prevention campaigns.

The Choose Life North Lanarkshire (hereafter NL) suicide prevention public awareness campaign has been conducted in a region characterised by a relatively young population, high poverty, low income levels, and high unemployment in more deprived localities (especially among males – at 11.2% in NL, July 2010-June 2011) (Nomis, 2012). The interaction between sex, age and deprivation suggests that suicide patterns may be expected to be fluid, responding to changing demographies, gendered norms and relations, and socio-economic conditions. While a focus on young men is justified by long-term suicide levels, this fluidity raises strong concerns about heightening risks among middle-aged, older, and unemployed men.

Choose Life in NL began in 2007 building on the national Choose Life campaign, launched in 2002, which aimed for a reduction in suicides of 20% by 2013. The strategy highlights people affected by unemployment, in rural communities, recently bereaved, or homeless. In NL a particular focus was on the National Objective of 'Awareness-raising and encouraging people to seek help early', and on young males. The NL programme aims to help reduce suicide levels, through increasing awareness of

crisis service numbers such as Samaritans and Breathing Space and challenging the stigma around suicide. The campaign was promoted with a social marketing approach to different age groups in targeted settings including pubs, pharmacies, libraries, workplace washrooms, Motherwell Football club, five-a-side football tournaments, taxis and buses, music festivals, and community centres, and through national media, using support materials such as billboards, posters, cards, DVDs, branded football products, newspapers, TV and radio. Desired 'intermediate' outcomes, expected to contribute to the long-term outcomes of suicide reduction, include: improved public access to information; increased public knowledge; and reduced cultural stigma.

The evaluation team were appointed to conduct the Choose Life NL evaluation, from March 2011. Key evaluation questions concerned identifying: a) programme effectiveness; b) benefits to the community as a whole and to targeted groups, particularly young men aged 16-35; and c) contributions being made by community to the programme's current and future effectiveness.

Choose Life is a complex programme, with multiple strands (including training and awareness-raising campaigning) and priority groups, organisational complexity around partnerships and funding, and regional flexibilities in scope and delivery (Mackenzie et al., 2007). In NL, challenges concerning campaign reach and sustainability made it crucial to examine change processes where the campaign is proving effective, and how best to apply learning for programme development. Choose Life was understood by the evaluators as a community-focused initiative, with interacting components, (MRC, 2008). Change cycles start with strategic planning, with stages of implementation, learning, and strategy refinement (Blamey et al., 2008). Complex changes can be influenced by interacting programme elements, other 'secular' trends (Mackenzie et al., 2007), and adaptability of local systems to their community environments (World Health Organisation, 2009). This article highlights emerging themes around change processes for strategy refinement, supported with evidence from discussion groups with the general public from the involved communities.

Methods

Considering the programme complexity, the evaluators adopted mixed qualitative and quantitative methods. This paper, because of its focus on examining change processes, presents qualitative data from Phase three (below). Phase one reviewed current datasets held by Samaritans, Breathing Space, and NL A&E admissions, examining whether the programme led to increased use of crisis numbers. Phase two included a survey of public awareness of the campaign in NL (including over 500 members of the general public with quotas for age, gender and location), and interviews with 20 key stakeholders to examine campaign processes and targeting. At Phase three, 10 discussion groups with men and women were held at different geographical locations to provide insights concerning awareness of call numbers and de-stigmatising attitudes; aspects of the programme which worked best; benefits to the community; and contributions the community are making to the programme. Recruitment of members of the public was facilitated by 'champions' of community networks such as football supporters, community sports and arts, and youth music festival volunteers, who were identified through the earlier stakeholder interviews. The age and gender compositions of the groups (reflecting the priority targeting of the campaign to males) were: 3 x 16-25 male; 2 x 16-25 female; 1 x 26-35 male; 3 x 36+ male; 1 x 36+ female. Discussions were conducted in small groups of 3-6, lasting 1.5- 2 hours, were digitally recorded, fully transcribed, and further session notes taken. Qualitative data were entered into NVivo and analysed thematically, through descriptive and analytic coding with codes then clustering under theme headings.

Ethics approval was granted through the appropriate University research ethics committee. Discussion group participants received information sheets in advance explaining the purpose of the evaluation and were free to withdraw at any time. Digital recording only occurred after written consent had been obtained from participants. Individuals were also assured that their anonymity would be protected during the reporting of findings. A possible limitation, assuring anonymity where

focus group members may discuss topics outside the group, was considered less serious because the groups consisted of members of the public, and were not known recipients of mental health services.

Findings

This section highlights interim achievements of the campaign at the time of the evaluation (approximately four years in to a six year campaign). Summary qualitative findings concerning the Choose Life (NL) campaign's community-based, male-focused direction are included selectively within a thematic discussion of *interim achievements around awareness, attitudes and behaviour;* and *engaging with the public as 'influencers'*.

Interim achievements around awareness, attitudes and behaviour

A literature review for the evaluation report (BLINDED et al., 2012) identified two main approaches in public awareness campaigns *aiming to reduce suicidal acts*; type a: those using language with a focus on mental health, and type b: those using language with a sense of urgency and clear focus on intense distress and imminent action. Choose Life (NL) campaign belongs to type b, and interestingly and unusually includes direct reference to suicide.

Awareness

Discussion groups expressed the view that the campaign has had a considerable impact in raising the awareness of a substantial proportion of the general public, specifically about the Choose Life brand and type b. strap-line ("Suicide. Don't hide it. Talk about it") challenging stigma and offering call numbers. Discussion groups suggested, (and survey data collected for the evaluation further confirmed, (BLINDED et al., 2012)), that this awareness was greatest in geographical areas where campaign resources were concentrated. Campaign elements focused on *awareness* had the objectives of letting people know they can help others or call for help. The public nature of the

campaign contributed significantly to raising initial awareness by putting the issue in front of people in family or community settings.

"Previously you didn't talk about it. The fact it was it was out there at football and on the TV [national TV advert], that changed people." 26-35 m

Awareness was increased - and some stigma mitigated - when men saw the message routinely being endorsed, over time, within trusted settings where they normally go as a lifestyle activity. Brand consistency, and innovation in messaging and placement retained people's attention in the face of competing consumer messages.

"More variety in advertising and more advertising in places where we're all going to be." 16-25 m

Attitudes and behaviour

Discussion group participants suggested that the attitudes of men, among those who were well aware of the campaign, were likely to have changed. Participants themselves asserted they were more open to talk about vulnerability, feeling low, or suicidal thoughts.

"Definitely helped me do something because I was a wee bit depressed a year ago and through Choose Life, getting over my problem I managed to help a couple of my friends." 26-35 m

The campaign was likely to have powerfully increased the confidence and capacity of people highly campaign-aware, including young men, to talk to others in their community or to seek help, it was suggested by discussion groups. Among highly aware men, it was considered to have 'normalised' talk about suicide, and increased awareness that it is *normal to feel 'low'*, and to *communicate concern* about mental health and emotions. More people would be watchful in communities and less likely to stigmatise another's distress.

"You wouldn't say 'pull yourself up by the boot straps' or 'get your act together'. " over 36 m

However, superficial awareness of the campaign strap-line and call numbers, from seeing a fleeting 'message', was considered to be insufficient to lead to sustained attitude or behaviour change. It was identified by members of the discussion groups that such a change takes considerable time, a reasonably high level of awareness among men, and sustained campaign presence.

"attitudes are generally so deep rooted it's not an easy thing to change. It's a long term thing." 26-35 m

Particularly for young men, a masculine 'ideal' of emotional contained-ness is transmitted *inter-generationally* and reinforced in male peer groups, it was said, closing off avenues of help-seeking or emotion talk. Challenges remained in encouraging a larger proportion of young men to *discuss suicide*.

"But again that's a generation thing, because your dad never cried, your grandpa never – how do you break that? Having the confidence and trust to go and talk to that person and know you'd get a positive response. " 26-35 m

"Even a group where several men might feel depressed, if one man speaks up, no-one really wants to speak about it." 16-25 m

The campaign's effects were also felt by men to be limited by a common male preference for information seeking rather than discussing suicide. It was suggested that a proportion of men would respond to the campaign by seeking information or help privately while still not talking with others in the community (and survey data collected for the evaluation appeared to confirm that the most common action amongst men was getting information on suicide/mental health issues, whilst the most common activity amongst women was discussing suicide/mental health issues after viewing campaign messages) (BLINDED et al, 2012).

"Individuals are not talking to others about it. It is still being kept a secret. It may be working but we don't know it is working because nobody is talking about it." 16-25 m

So, whilst some processes of normalising talk around suicide and reducing stigma were apparent, there was still progress to be made in certain social contexts, particularly those involving peer groups of younger men.

Engaging with the public as influencers

Campaigns using language with a sense of urgency and with a focus on intense distress and imminent action (type b) require a targeted variety of resources, not only for people at risk, e.g. specific online, radio and television presentations for young men who may be socially withdrawn (NHS Health Scotland, 2010), but for the general public who might influence them, e.g. billboards featuring a campaign strap-line and call numbers at a football club, and panels on taxis and buses.

The combined use of community settings appealing to targeted groups and settings with more widespread appeal was considered by men in discussion groups to be important for achieving campaign objectives. Use of public transport (including taxis where drivers had been trained to talk about the issues with men), television and radio effectively reached a wider public. Use of Motherwell football ground, five-a-side tournament, pub and festival settings provided male-friendly environments where public awareness could be initiated. In 'trusted' leisure contexts, men may be subconsciously more receptive and less defensive, discussion groups said. However, it was also suggested that men may be more likely to notice than to talk about the message during or directly after a match. Further thought then needs to be given to following up messages with follow-up support encouraging men to talk in trusted contexts.

"Life can be chaotic and problematic but if you go to football you generally don't give that [football] up, for ninety minutes it's an escape so it really is a great place to advertise that" 26-35 m

"It'll probably surprise you what you take in without realising." over 36 m

"Lots will get that message at the football. Nobody's ever come to me then and said 'I saw this'. Nothing like that." 26-35 m

Focusing on different age groups was considered important. Younger people in the discussion groups (16-25) favoured messages in preferred lifestyle settings, for example fashion (shops), and music (festivals). Participants were, however, unsure if materials were reaching marginalised or disconnected groups, and felt more materials might be placed in job centres, and other social support settings. Illustrating the challenge of diversification, men within minority groups (by ethnicity, or sexual orientation) may have been led by experience to mistrust how services would use information.

"There are plenty of suicides about that. [Among LGBT people] 30% don't want to phone up. Don't want to be a statistic." 16-25 m

Clarity about target audiences and behavioural goals was felt to be important. The prominent 'strapline' message ("*Suicide. Don't Hide it . Talk about it.*") initially attracted attention, **evoked emotions in people who had been touched by suicide in their community and experienced the shroud of silence, and challenged gender and cultural barriers by directly naming the taboo theme.** However, discussion groups were concerned how the message would be interpreted by community members who might influence men at risk, and how far the campaign provided a clear guide to action ('next steps'). Discussion groups (of men), perhaps reflecting wider public narratives about gendered communication, implied that men might ignore an ambiguous message rather than negotiate further clarification. The male public, family and friends might feel uncertain whether the strapline message to 'Talk' applied to them, or if the call line services would provide advice to them. An offer of training or advice to the public would be welcomed.

"It was targeting everybody, and there's two types of folk. There's the 'you might be talking to somebody who's thinking about killing themselves' or 'you might be the person'." over 36 m

A different football poster message '*Help a Friend Stay in the Game*' addressed the public explicitly with further guidance to action, but might not have had the same initial impact, as it did not mention 'suicide' explicitly in the strapline.

Varied strategies were needed for men, it was felt, including male-friendly stories/narratives, and role models, in different media, to foster empathetic engagement. Use of credible (male) role models, telling their stories, was said to have a big potential impact on otherwise disengaged community members.

"The campaign needs stories that folk can identify with." over 36 m.

It was further suggested in discussion groups that people with high potential influence, such as barbers, postal workers and shop workers, and more community/voluntary sector workers in areas like physical and leisure activities should undergo basic training towards engaging with the public on suicide prevention. This approach had been piloted in that some taxi drivers had been trained to talk with men who saw the message on vehicle panels. This was felt by men in discussion groups to be a good development which would encourage men to open up about their concerns.

"People like human contact. If you can talk to your taxi driver, hairdresser, maybe that's going to help you. How do you train people, and give them confidence to approach a person?" 26-35m

"Basic level training. So people feel more confident, less exposed with the public." over 36 m

While the campaign targeted young adult men successfully, the discussion groups also stated it is vital to reach out separately to middle-aged and older men at risk, for example after unemployment. There is also every reason, as discussion groups said, to target future generations in schools more widely.

"Beyond a certain age it's harder to influence them." over 36 m

Discussion

This section highlights emerging considerations for further programme development in the context of preventing suicide among young men, and considers learning from the evaluation around strategic development for: *extending the engagement of the public beyond initial awareness-raising; gender issues*; *the co-ordination of public awareness campaigning and training*; and the development of *networks* of *'trust'* towards a wider cultural transformation. To achieve this, a wider evidence base from the broad Choose Life programme, and from research on mental health and masculinities is referenced alongside the evidence from the qualitative discussion groups.

Engagement through stories

The above findings concerning the need for a variety of approaches indicate that an interacting, coherent range of strategies and messages is needed to extend and support public engagement beyond the initial awareness-raising levels. Varying communication, for targeted sections of the public, makes sense in terms of different lifestyle preferences, and positions of awareness, attitude change, and sustained engagement. Storylines can unpack subconsciously held cultural scripts, and characters invite empathy, to explore peer influence, and to 'normalise' people who have suicidal thoughts. Television drama reaches broadly to individuals and families, and online videos and music reach young adults. Positive Mental Attitudes in Glasgow uses film and community theatre to discuss suicide prevention in communities http://www.positivementalattitudes.org.uk/ . Time to Change campaign http://time-to-change.org.uk/ includes personal stories and narrative videos. 'See me' campaign in Scotland uses 'Case' stories of organisational 'champions', and story-writing competitions around 'support' (http://www.seemescotland.org/getinvolved/). Similar approaches can extend the reach of a type b. suicide prevention campaign.

Gendered and age-specific targeting.

Communication around practical activity has engaged men (Robertson, 2007), so a good direction can be to support men within informal/semi-formal community networks towards combining practical action with communicating around suicide: arranging or participating in events, or guiding others to services. For example, young people cascaded messages across peer networks while contributing practically to organising festivals (e.g. 'Sound Minds'). A community development approach involving asset mapping (McLean, 2011, 2012) was advocated by members of the public and stakeholders, to spread change and renew the campaign.

The wider evidence base attests to the risk for unemployed men (Canetto and Clearly, 2012) **and reinforces the importance of targeting this group**. In Scotland, by 2009, the suicide rate for males was highest and rising in the early middle age groups (30-49) (Samaritans, 2011). Key risk factors alongside psychological/personality attributes include disadvantaged socio-economic position, episodic or sudden unemployment, relationship breakdown, social disconnectedness, and the interface of generation and gender (masculinities) (Samaritans, 2012). Middle-aged disadvantaged men, vulnerable to economic change and recession, and changes in family composition, have been viewed as potentially 'trapped' generationally between traditional and emergent masculinities, with diminished options for agency and affirmation of identity (Samaritans, 2012).

Wider evidence also shows that a substantial proportion of lifetime mental health concerns begin to emerge before adulthood, while gendered relational patterns are still forming, **which points to the importance of engaging with future generations in schools** (Scottish Government, 2011; HM Government, 2011; Samaritans, 2012).

The potential influence of women should also be considered, as discussion groups noted, confirming survey evidence from our evaluation which appeared to indicate that more women than men have

discussed suicide following the campaign (BLINDED et al., 2012). Previous research suggests that women are responsive to suicide campaigns in terms of discussing issues, affecting behaviour (particularly within families) (O'Brien et al., 2007), and providing support.

Co-ordination of training with public awareness campaign

Reflecting on the evidence from Choose Life in the context of comparable programmes, there is a need for suicide prevention campaigns to consider links between the public awareness campaign work and training. In the Nuremberg Alliance against Depression campaign, overall reduced suicidality was attributed to additive and synergetic effects of a four-level programme structure: 1. Training primary care physicians; 2. A public media campaign; 3. Gatekeeper training of community members whose role might make them pivotal in help-seeking amongst suicidal/depressed people; 4. Self-help groups for suicide attempters and relatives (Hegerl et al., 2006).

Choose Life (NL) worked vigorously for suicide prevention through extensive training of NHS, local authority education and voluntary sector staff (level 1); and a public media campaign (level 2). Level 3 (gatekeeper training) was initially part of the national campaign. However, few community members participated in a non-professional capacity: only 2% of those trained nationally between April 2007-March 2010 (Griesbach and Russell, 2011), a pattern reflected in NL.

The additive and/or synergetic 'preventive' effect of public awareness-raising and training programme elements could perhaps be amplified if training of 'community' gatekeepers who directly interact with targeted sections of the public was increased while awareness campaigning focused clearly on these sections.

Targeting gatekeepers as champions

Gender is a key consideration for the recommendation to redirect training to build community capacity, in the national evaluation of Choose Life training (Griesbach and Russell, 2011; Choose Life, NHS Scotland, 2011a; 2011b). Most suicide awareness course attenders in Scotland to date have been women (80%), reflecting the composition of the public sector workforce (64% women) most represented on courses, whilst most interventions from those trained have been with women (60% among those surveyed nationally)(Griesbach and Russell, 2011). However, men carry out the majority of suicides. From the above analysis of national contact data and our discussion group evidence, training may need to include more men who have frequent contact with men in the community, especially those at high risk. Targeting 'male settings' was a key feature of Choose Life NL awareness-raising, but training broadly followed the national pattern in Scotland. If more community/voluntary sector members of homelessness services, clubs, pubs and workplaces were trained, consideration should be given to their role and support needs.

Masculinity and trust

To explore the importance of 'trust-building' community networks for males within suicide prevention, we interpret men's help-seeking practices within a social view of men's identities as potentially multiple, developed relationally by taking up positions within wider cultures, involving tensions, contradiction and the 'pain of belonging or not belonging' (Frosh et al., 2002, p.174). Gender theory conceptualises masculine identities in terms of social practice in everyday life: developed through social (inter-)action (Connell, 1995), intersecting with other dimensions of identity, such as class (Frosh et al., 2002). The relational construction of multiple masculinities (Ridge et al., 2010) is viewed as referring to a plural, hierarchically arranged order including hegemonic (i.e. dominant), and other (e.g. marginalized) masculinities (Connell, 1995, p.77; Robertson, 2007).

From this perspective, in everyday life men often 'perform' masculinity through routine social-relational behaviours tending to reproduce a core masculine identity. Given the dominant

expectation of self-reliance, many men are routinely less willing or able to express emotions such as fear or sadness (White, 2006; Lee and Owens, 2002). Yet this 'positioning' may potentially shift, in different social contexts (Robertson, 2007). A premise of the Choose Life campaign, with its strapline "Suicide, don't hide it. Talk about it", is that in some socially 'trustworthy' community contexts men may be supported to talk about vulnerability without feeling less 'masculine'.

Networks and trust-building

Strengthening community capacity around suicide prevention can contribute to developing trust and resilience in communities. Here, trust concerns normalising and making 'safe' talk about emotions. Resilience concerns the "capacity of individuals, and systems (families, groups and communities) to cope successfully in the face of significant adversity or risk" (Lyons et al., 1998: p.591). Where economic disadvantage is worse, social networks as community assets can play a vital protective role (Poortinga, 2011). If the cultural stigma over suicide and gendered barriers to communicating vulnerability are shifted, so more people talk in trusted networks about how they feel, and offer and seek help in a timely way, community resilience can be increased, towards suicide prevention.

Our evaluation raised the following considerations. Developing trusting relations -'social capital'- and community resilience fits closely with the intermediate outcomes of increased social connectedness and trust, modelled in the Scottish strategy for mental health improvement (Scottish Government, 2009, p.11). 'Social capital' concerns positive, trusting, relationships between members of a society. It has been understood in terms of the nature and extent of social networks and associated cultural norms of reciprocity (Putnam, 2000). Social capital as a capacity of a 'group or network' includes resources flows (e.g. supporting information exchanges around health), the social infrastructure of networks, and power structures around networks (Szreter and Woolcock, 2004).

Three very relevant forms of social capital have been distinguished: bonding, bridging, and linking capital (Szreter and Woolcock, 2004). "Bonding capital refers to trusting and co-operative relations between members of a network who see themselves as similar in terms of shared social identity" (Szreter and Woolcock, 2004: p. 654), for example friends, neighbourhood football fans. "Bridging social capital comprises relations of respect and mutuality between people who know that they are not alike in some socio-demographic (or social identity) sense (differing by age, ethnic group, and class)". "Linking social capital" is defined as "norms of respect and networks of trusting relationships between people interacting across explicit, formal or institutionalized power gradients in society" (Szreter and Woolcock, 2004: p. 655). Strengthening all three is salutogenic, and can potentially improve health outcomes, especially by facilitating flows of resources through interaction (Szreter and Woolcock, 2004: p. 655).

There is potential for developing campaign initiatives in tight cohesive networks of people with strong associational bonds (for example *men at the football stadium*), in networks bridging age, class, and gender divisions (e.g. at *cross-generational* festive events), and in networks developing links between *professionals and the general public*. Choose Life (NL) campaign targeted specific groups of men where strong bonds exist. The potency of this for information and support drawing on community solidarity might be reduced if group members lack the knowledge to assist each other *and/or* share a 'defensive' culture inhibiting trusting communication on mental health. Cohesive networks, particularly with traditional masculinity, can constrain behaviour due to strong social norms (Poortinga, 2011). For example, men at a football match might see Choose Life billboards but might not discuss them with peers, as men in discussion groups observed.

"Lots will see that message. But nobody's ever come to me after the game and said 'I saw this'." 26-35 m

Choose Life, in Scotland, targets people across age, gender, and class divisions through 'universal' media approaches (e.g. television, music festivals) and cross-generational community comedy and arts events. Despite the potential for wide outreach, questions persist about where cross-group networks are strong enough for trusting communication about men's mental health. The campaign has been co-ordinated by organisations including NL Council, Scottish Association for Mental Health, Samaritans, and Breathing Space, linking with enterprises such as Motherwell FC. Here the challenge is to build trusting relationships 'vertically' through links between formal services and the public. "If you saw the information you could want to discuss how you're going to help somebody if you've heard somebody's contemplating it." over 36 m

Identified challenges around trust-building concern stigma surrounding mental illness, gendered mistrust of communicating vulnerability, and engaging with marginalised groups. Involving and *training* 'well-connected' champions, particularly men, in community, voluntary and business sectors, as well as 'gate-keepers' in public services, can potentially help strengthen the positive, trusted networks of members of the public who work towards suicide prevention. This community asset-based approach would complement the essential work of trained professionals. Asset based approaches 'value the capacity, skills and knowledge and connections in individuals and communities. They focus on the positive capacity of individuals and communities rather than solely on their needs, deficits and problems' (Mclean, 2011, p.4). Trained people, in settings where individuals may have strong bonds might include five-a-side football co-ordinators, barbers, and bar staff. Trained people in 'cross-group network' settings might include festival or community arts workers, a focus for information and support and a link between networks. In formal retail and workplace settings, trained people can champion organisational approaches. Trained professionals can link services to social networks, through champions, who they support.

Reaching unemployed, disconnected, and isolated men, in weakened networks, is a major priority. Both professional 'gatekeepers' (e.g. job centre, finance/welfare advice, housing, homelessness, substance misuse, court and other support workers) and trained members of those networks could potentially contribute.

Conclusions: implications for research and practice

This article has explored how a formative evaluation, examining interconnecting change processes, can assist suicide prevention programme developers in understanding progress and planning further steps in a complex awareness-raising programme aiming at culture change, and prioritising men. At an intermediate stage towards sustained suicide reduction, the Choose Life NL evaluation found evidence of raised capacity and confidence of targeted sections of the public, especially young males, to seek and give help across their networks of influence.

The campaign community-settings approach has been a pathfinder in Scotland, aiming to support a culture transformation to an attitude of enabling trust. As the introduction to this paper shows, male suicide is a Europe-wide issue, exacerbated during times of economic austerity and the lessons from this campaign have broad relevance. Cultural and service transformation takes time. Achieving transformation requires a multi-facetted, systems focus on the public, individuals and organisations, developing, supporting and celebrating approaches which draw on the physical, social, emotional and cultural assets of communities (McLean and McNeice, 2012). National policy drivers need to be maintained, recognising suicide as a gendered health inequality. This can encourage programmes to pursue: co-ordination of national and regional resources; strengthening cross-sectoral and community-centred partnerships and networks to reach existing/emerging high risk groups (highlighting the intersection of gender, generation, relationship patterns, and socio-economic position in identifying these groups); and co-ordination with wider anti-stigma and mental health

programmes. The focus on coordinating training and awareness-raising, developing trust and mobilising community assets can help with this.

This paper has indicated the importance of understanding the intersection of gender and other protective factors which can inform campaigns highlighting talk about suicide among men. Further research should focus on specific ongoing initiatives, acknowledging the time required for building on community assets, and asking 'what works for whom in what circumstances and in what respects, and how?' – a realistic evaluation (Pawson and Tilley, 2004: p.2; Blamey and Mackenzie, 2007). There is a need to comprehend more about the protective potential of differing social networks in supporting suicide prevention for men, and how community focused training and support might influence this.

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